MEDPAC Medicare Payment Advisory Commission

TESTIMONY

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Medicare's Special Payments and Patient Care Costs

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Chairman Roth, Senator Moynihan, members of the Committee. I am Murray Ross, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I am pleased to participate in this hearing looking at Medicare's special payments and patient care costs. My testimony today is intended to provide you with background information about Medicare's policies and not to support or oppose any particular policy option under consideration.

For this hearing, the Committee asked MedPAC to describe Medicare payments to providers that are not directly linked to patient care services for beneficiaries. Policymakers' interest in this topic stems from questions about how provider activities supported by these special payments should be financed if the Medicare program were put on a more market-based footing. Where Medicare's special payments support activities that benefit society at large, they raise program spending and beneficiaries' premiums above what they would otherwise be. Beneficiaries might be unwilling to bear the costs of those activities through the premiums they paid to private health plans in a restructured program.

Classifying special payments

Several reasons make it difficult to describe Medicare payments not specifically linked to patient care. First, some payments that are commonly asserted to be for things other than patient care may in fact cover patient care costs. The payments Medicare makes to teaching hospitals for the direct costs of graduate medical education may fit in this category. Second, some payments that look like patient care—because they are made for specific units of service to Medicare beneficiaries—may cover costs other than patient care. Some portion of the indirect medical education adjustment that Medicare makes in setting payments to teaching hospitals for inpatient hospital stays fits in this category. Finally, in some situations Medicare may pay providers more than their average cost of providing care to Medicare beneficiaries. Medicare's payments to disproportionate share hospitals cover a portion of the cost of patient care for people other than Medicare beneficiaries. Special provisions for rural providers and payment floors in the Medicare+Choice program reflect the higher costs of producing services at low volume and the difficulties of operating health plans when both enrollment and provider supply are low. These policies are often seen as a way of maintaining beneficiaries' access to those providers and fostering the availability of choices.

My testimony today discusses these examples in more depth and points out the

factors that policymakers need to consider as they weigh alternatives for reshaping the Medicare program.

Medicare's direct medical education payments to teaching hospitals

Medicare pays teaching hospitals an amount, separate from payments under the inpatient prospective payment system (PPS), for the direct costs of operating residency programs. These payments—known as graduate medical education (GME) payments—reflect salaries and benefits for residents and supervising physicians, office costs, and other overhead. The Congressional Budget Office (CBO) estimates that Medicare GME payments totaled $2.5 billion for fiscal year 1998, of which $2.2 billion was paid for residency training and $300 million was paid for nursing and allied health training.

When PPS was first enacted, Medicare paid its share of hospitals' full GME costs. Since the late 1980s, however, payments have been based on hospital-specific per-resident amounts, calculated using 1984 costs updated for inflation and based on Medicare's share of inpatient days, not its share of costs.[1] Several additional rules affect what is actually paid. First, residents in their initial residency period—up to five

[1] Medicare's share has been calculated as the fraction of total inpatient days accounted for by Medicare fee-for-service beneficiaries. Beginning in 1998, a percentage of inpatient days accounted for by Medicare+Choice enrollees has been included in the calculation. That percentage will increase gradually until all days are taken into account in 2002.

years—are counted in full toward payment, while those beyond the initial period are counted as half time. Second, the Balanced Budget Act (BBA) of 1997 capped the number of residents hospitals may include in their count at the 1996 level (although a 3-year rolling average of resident counts is now used to cushion the effect on hospitals that reduce the size of their residency programs). Finally, the per-resident amounts are set slightly higher for residents in primary care and related specialties.

Many observers view payments for the direct costs of graduate medical education as a subsidy to teaching hospitals—and ultimately residents—unrelated to the costs of care for Medicare beneficiaries. But economic theory suggests why this may not be so. In preparation for our forthcoming report on graduate medical education, MedPAC's Commissioners have considered whether hospitals' training costs are borne by residents in the form of lower salaries. If that is the case, the direct costs actually represent the costs of patient care rather than training costs. This conceptual approach, however, does not tell us whether the current level and distribution of GME payments is appropriate.

This idea stems from an accepted proposition in economics that in competitive labor markets, rational employers will be unwilling to pay for the costs of general training—training that makes workers more productive in all settings, not just that of a particular employer. This result occurs because employers cannot recoup the costs of

such training through workers' higher future productivity; if they tried to do so, workers would move to other employers where their training was equally valuable. Workers who want general training must therefore pay for it by accepting lower wages; they are willing to do so because acquiring training allows them to earn higher wages in the long run.

If this general proposition holds in the context of teaching hospitals, then all of the direct costs of graduate medical education can be attributed to patient care. Although Medicare might appear to be paying for costs that are not directly related to patient care—salaries for supervising faculty, overhead, and the like—the payments it makes for the costs of residents' stipends are lower by that same amount.

In practice, the matter is considerably more complex, and reality does not always conform to economic theory. But as a general concept, this proposition implies that discussions about whether Medicare should pay for direct GME should not center on the issue of whether the program is subsidizing residents' educations. Rather, the focus should be on whether the additional costs of care from having residents reflect a difference in product for which society is willing to pay. (The next section discusses this point further.)

Medicare's indirect medical education payments to teaching hospitals

In addition to GME payments, Medicare adjusts teaching hospitals' operating payments to reflect their higher costs per discharge that cannot be directly attributed to teaching activities. These indirect medical education (IME) payments totaled $4.1 billion in fiscal year 1998, according to CBO.

The IME payment amount depends on hospitals' teaching intensity, as measured by the ratio of residents to beds. When PPS was enacted, the adjustment was set at 11.6 percent for each 10 percent increment of teaching intensity. This adjustment was double the estimated relationship between residents per bed and Medicare operating costs per discharge. Since then, the IME adjustment has been reduced several times, most recently by the BBA. The BBA reduced the adjustment from 7.7 percent in 1997 to 7.0 percent in fiscal year 1998, 6.5 percent in 1999, 6.0 percent in 2000, and 5.5 percent in 2001 and later years.[2] (For comparison, MedPAC's most recent estimate of the effect of a 10 percent rise in residents per bed on costs per discharge is 4.1 percent.)

The BBA also established a separate IME payment to teaching hospitals that treat

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[2] In 1999, operating payments to a teaching hospital with a resident-to-bed ratio of 0.6 (typical of an academic medical center) are increased by about 33 percent. Payments to a teaching hospital with a resident-to-bed ratio of .083 (typical of teaching hospitals other than academic medical centers) are increased by about 5 percent.

Medicare beneficiaries who are enrolled in Medicare+Choice plans. That payment is being phased in over a 5-year period beginning in 1998.

Medicare's IME payments have been justified on the grounds that they compensate teaching hospitals for several factors that raise their costs but which cannot be separately identified:

- a more severe case mix that is not reflected in Medicare's DRG payments,
- special capabilities, such as the presence of trauma centers and burn units,
- unsponsored clinical research, and
- higher quality of care related to teaching hospitals developing—or being early adopters of—new diagnostic and therapeutic technologies.

In reviewing Medicare's payment policies, MedPAC believes that, other things being equal, Medicare's payments should reflect the costs an efficient provider would incur in providing patient care. By this standard, Medicare's IME payments clearly reflect patient care costs to the extent they correspond to a more severe case mix than is found in other hospitals. Where teaching hospitals' higher costs reflect a different product, or when payments finance social missions other than patient care, policymakers may ask whether those payments should be made by Medicare or some other way.

Medicare payment policies intended to maintain access and foster choice

A number of Medicare payment policies are intended to maintain access to care for Medicare beneficiaries and to foster choices among different providers and types of private health plans. These policies include disproportionate share (DSH) payments made to hospitals that treat large numbers of low-income patients, provisions for special payments to hospitals and other providers in rural areas, and the floor payments established in the BBA for Medicare+Choice plans.

These policies may be justified in different ways. DSH payments are intended to compensate hospitals that provide above-average amounts of care to low-income patients. If Medicare and other payers' payment rates covered only the costs of patient care for their own enrollees, hospitals would not be able to make up for the uncompensated costs of care furnished to low-income patients. Consequently, hospitals might seek to treat fewer low-income and uninsured patients. Special payments to rural providers and the floor payments to Medicare+Choice plans in some counties reflect a slightly different rationale. Because rural providers and plans must generally operate on a smaller scale, they cannot exploit economies of scale. Accordingly, their average costs will be higher. If Medicare paid only the costs of an efficient provider in average

circumstances, its rates might not be sufficient for low-volume providers to continue in operation or to induce health plans to enroll beneficiaries in some areas.

Disproportionate share payments

The disproportionate share (DSH) adjustment was implemented in 1986, the third year after PPS began. An estimated $4.5 billion was spent on the DSH adjustment in fiscal year 1998. The BBA reduced DSH funding by 5 percent, in single percentage point increments implemented from 1998 through 2002.

DSH payments are distributed through a percentage add-on to Medicare's DRG payments for inpatient hospital stays. The add-on hospitals receive is determined by a complex formula and the share of their services provided to low-income patients. The low-income share is the sum of two ratios—patient days for Medicaid recipients as a share of total patient days and patients days for Medicare beneficiaries who are eligible for Supplemental Security Income as a percentage of total Medicare days.

The adjustment was originally justified on the assumption that because poor patients were more costly to treat, hospitals with substantial low-income patient loads would have higher Medicare costs per case than would otherwise similar institutions.

That assumption has not borne out, however, and the DSH adjustment has increasingly been viewed as serving the broader purpose of protecting access to care for low-income Medicare and non-Medicare populations by assisting the hospitals they use. In both its March 1998 and March 1999 *Report to the Congress*, MedPAC has relied on this premise in recommending changes to the DSH adjustment. The Commission believes that DSH payments could be made more equitable by using a better measure of care to the poor and by using a distribution formula that more consistently links hospitals' DSH payments to their low-income share. Under MedPAC's proposal, the low-income share would be broadened to encompass all low-income groups by including uncompensated care and measures of care covered by local indigent care programs. The same distribution formula would be used for all hospitals, in contrast to the current 10 formulas that provide a wide range of payments for hospitals serving the same proportion of low-income patients.

Special payments to rural hospitals

Several provisions of Medicare payment policy increase operating payments for certain classes of rural hospitals above what they would otherwise receive under the PPS. These classes include sole community hospitals, small rural Medicare-dependent hospitals, reclassified hospitals, and rural referral centers. Some rural hospitals may benefit from more than one of these provisions.

Sole community hospitals. Sole community hospitals are geographically isolated providers representing the only readily available source of inpatient care in an area. These hospitals are paid the highest of three amounts: the PPS operating payments that would otherwise apply; a hospital-specific amount per discharge based on their operating costs in 1982, updated to the current year; or an amount per discharge based on their operating costs in 1987, updated to the current year. About 700 facilities are designated as sole community hospitals.

Small rural Medicare-dependent hospitals. These are rural hospitals with fewer than 100 beds and whose Medicare share of days or discharges exceeds 60 percent for the cost reporting period that began during fiscal year 1987. For discharges occurring in fiscal years 1998 through 2001, these hospitals receive PPS operating payments plus 50 percent of the difference between their updated hospital-specific base year amounts (1982 or 1987) and the PPS rate. About 370 hospitals meet the qualifying criteria.

Reclassified hospitals. Hospitals that meet certain criteria may be reclassified by the Medicare Geographic Classification Review Board to an area other than the one in which they are physically located. In most cases, hospitals are reclassified from a rural area to an urban area or from an other urban area to a large urban area. Reclassification may affect either the standardized payment amount (the basic payment rate under PPS) or the

wage index (an adjustment made to the labor component of the standardized amount to reflect local labor market conditions). Even though the standardized payment amount does not vary between rural and other urban areas, hospitals reclassified for this purpose may benefit by qualifying for DSH payments (or for higher DSH payments) as urban hospitals. Rural hospitals reclassified for the purpose of the wage index receive a higher adjustment to the labor component of their standardized rate. In fiscal year 1998, 314 rural hospitals were reclassified for one or both of these reasons.

Rural referral centers (RRCs). Rural referral centers are rural hospitals that meet criteria regarding the number of beds, annual discharge volume, case-mix index, or proportion of care furnished to patients referred from outside their local area. The standards RRCs must meet for geographic reclassification are less stringent than for other hospitals, allowing many to qualify for a higher wage index and for DSH payments as urban hospitals. Each of these provisions raises PPS payment rates for RRCs relative to what they would otherwise receive.

Special payments to other rural providers

In addition to special payments to rural hospitals, Medicare payment policy includes provisions for special payments to other providers, including rural health clinics and physicians providing services in Health Professional Shortage Areas (HPSAs).

Rural health clinics. To promote access in rural areas with scarce medical services, P.L. 95-210, passed in 1977, authorized Medicare and Medicaid reimbursement to nonphysician practitioners providing primary-care services in rural health clinics. The clinics can be independent, or they can be part of a larger facility, such as a hospital. Medicare payments are based on an all-inclusive rate for covered services provided during each visit. These rates are based on costs up to prospectively set limits. Small rural hospitals with fewer than 50 beds are exempt from these limits. According to a recent report from the General Accounting Office (GAO), the number of rural health clinics has grown by 30 percent per year since 1989. There were 3,000 clinics in 1996.

Physicians in Health Professional Shortage Areas. A HPSA is an area designated by the Secretary of Health and Human Services as having a shortage of primary-care providers. The Omnibus Budget Reconciliation Act of 1989 authorized a 10 percent bonus payment for services provided in HPSAs and reimbursed under Medicare's physician fee schedule. According to the GAO, about 46 percent of the $106 million in bonus payments made in 1996 were for services provided in rural areas.

Floor payments for Medicare+Choice plans

Until 1997, Medicare paid private health plans in any county 95 percent of the average per capita cost of care for fee-for-service beneficiaries in that county, adjusted for the demographic characteristics of Medicare beneficiaries in that county. The BBA broke the direct link between fee-for-service spending and payments to private health plans. Now, payments are the highest of a floor beneath which payments cannot fall, a 2 percent increase above the prior year's rate, or a blend of local and national payment rates (but only if a so-called budget neutrality condition is met).

In establishing payment floors, the BBA effectively raised monthly capitation rates in many counties above local fee-for-service costs of patient care. The objective of these provisions was to encourage private health plans to participate in areas (particularly rural areas) where they had not previously done so. In 2000, 944 counties—about one-third of the total—will have monthly capitation rates at the floor.

Medicare's special payments and market-based reform

How might the activities supported by Medicare's special payments for medical education, disproportionate share hospitals, rural providers, and health plans in floor

counties fare in an environment that relied more heavily on market forces? A definitive answer cannot be provided for each case, but analysis suggests that if the Congress is interested in continuing support for the these activities, it may need to find new mechanisms for doing so.

In regard to graduate medical education and Medicare's special payments to teaching hospitals, the answer hinges on the extent to which beneficiaries observe and value the difference in the services these hospitals provide. Just as consumers are willing to pay higher prices for goods and services they perceive to be superior—from automobiles to college educations—we can reasonably suppose that some Medicare beneficiaries would choose plans that contracted with teaching hospitals. We observe this today among the nonaged population and among Medicare+Choice enrollees whose health plans contract with teaching hospitals. Whether beneficiaries' premiums would provide the same level of support currently provided through Medicare cannot be known. However, to the extent that part of Medicare's payments support social missions beyond patient care, one would expect a decline.

With respect to Medicare's payments to disproportionate share hospitals, it is likely that support would decline under a market-oriented program. In the past, hospitals were able to offset at least some of the costs of uncompensated care by charging more to

insured patients. They have been less able to do so as the health care market has grown increasingly competitive, and private payers have resisted paying costs for people other than their own enrollees. Making Medicare more competitive would reinforce this trend. While the likely direction of the impact is clear, its magnitude is not. Health care markets are complex, and the ability of providers to pass on the costs of uncompensated care to payers varies from market to market.

The impact that moving to a more market-oriented program might have on support for providers in rural areas and health plans in floor counties is less clear and would depend in large measure on what the new program looked like. Discussions of market-oriented reform often assume that beneficiaries living in high-cost areas would receive a larger contribution toward their premium to reflect those costs. On the one hand, policymakers could provide greater support for beneficiaries living in areas where low volumes meant high average costs as they might do for beneficiaries living in areas where costs were high for other reasons (such as high labor costs). On the other hand, policymakers could choose not to recognize higher costs attributable to low volumes. In that case, market forces would encourage the expansion of geographic service areas if beneficiaries chose to incur greater travel costs in exchange for lower premiums that reflected greater volumes handled by providers.